ABSS Summative Evaluation

Participatory Action Research Report

ABSTRACT

The Evaluation Team at the University of Essex undertook the participatory action research (PAR) component of A Better Start Southend (ABSS) Summative evaluation. This report outlines the approach taken, the methods and analytical approach used, and presents a synthesis of our findings. Alongside a critical discussion of the findings, the report also sets out key recommendations.

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Outline

The Evaluation Team at the University of Essex led the participatory action research (PAR) component of the A Better Start Southend (ABSS) summative evaluation.

This report will first outline the approach that was taken to this component of the evaluation, including an overview of the methodology and it's benefits for researching this area of health and why it helps to address our research questions. This will be followed by an introduction to the various stages of the research, the participants involved and the methods that were applied. Subsequently, we will outline the forms of data thereafter collected, and the thorough and sophisticated methods of its analysis. The report will then detail the various sets of results individually, which is complemented by a critical synthesis bringing together the findings collectively.

Finally in this report we will draw upon the findings to outline recommendations and critical discussion points for practice, policy and research related to early years public health interventions and the ABSS programme delivery within the local context.

Introduction

The ABSS programme is a place-based initiative. It uses a life course approach, prioritising services and activities for families with children in the early years "to give every child who lives here the best possible start in life" (A Better Start Southend, n.d.).

There are varied options for evaluating place-based public health initiatives such as ABSS including more traditional evaluation approaches which may focus on a variety of outcomes (for example, exploring the quality of a programme, or its process). Evaluating effectiveness or direct health outcomes from an initiative - in terms of the impact it made on its target community - is likely to be multi-faceted and published evaluations of such vary in complexity and quality (see Burgemeister *et al.*, 2021). Quantitative approaches are dominant in these studies, despite criticisms of their narrow focus and reductive tools, though qualitative evaluation methodologies are increasingly recognised as valuable to unpack the "complex social environments" that many public health initiatives are situated in (McGill *et al.*, 2020, p.1).

Participatory evaluation is a powerful approach to enhance organisational learning that can result in better informed decisions (Cousins and Earl, 1995). It is an applied social research approach that involves the stakeholders of a programme, including those with programme responsibility, in the evaluation process. Thus, to complement the ongoing ABSS evaluation activities, we undertook participatory evaluation utilising participatory action research (PAR) to offer a unique approach to understanding the programme of work led by ABSS. This qualitative methodological approach was selected as it is helps better understand lived

experiences from an emic or insider perspective and can be used to "maximise participant's control over the production of knowledge" (Kapilashrami and Marsden, 2018, p.4).

PAR involves a collective and reflexive inquiry process that researchers and participants undertake to explore and analyse local knowledge (Kapilashrami & Marsden 2018), so that they can "understand and improve upon the practices in which they participate" (Baum, MacDougall and Smith, 2006, p. 854). In this way, the PAR component of the evaluation, targeted at ABSS programme managers and delivery staff, offers an opportunity for them to engage in reflective enquiry, learn the application of unique methods and in the process collectively identify areas and mechanisms for change. Within PAR, we utilised standard qualitative research techniques such as focus group discussions as well as service mapping and photovoice which were used to generate providers' knowledge about the main barriers and gaps in equity of access to ABSS services.

Research questions

The aim of the ABSS programme is to develop and test "new ways of supporting" Southend's children and families (ABSS, n.d.). The research questions for this component of the summative evaluation were:

- What are the barriers and facilitators in delivering ABSS services and for extending their reach to ensure healthy early years?
- What are the perceived barriers at individual, community, institutional or structural level that impede uptake of services?
- What are promising practices / approaches to enhance outreach and uptake, especially from those 'left behind'?

Methods

There were two phases to the PAR work, both of which involved running parallel pieces of work across the three ABSS workstreams based on health area/clinical speciality. These are:

1) Communication and Language development

2) Social and Emotional development

3) Diet and Nutrition

Phase 1

The first phase involved conducting one-to-one meetings and holding introductory sessions and focus groups with the ABSS workstream leads (n=3), programme leads (n=5) and

programme staff (n=4) to orient them to the evaluation task. This took place between April-May 2022.

These focus groups had two related objectives.

First, to gain an understanding of the organisations involved, their delivery of different ABSS services, and how they achieve outcomes. Central to discussion was also the barriers and challenges in delivering ABSS services. Participants were asked to discuss areas of the service/programme/context that they wanted to 'understand more about'.

Second, and aligned with the principles of participatory research, was to achieve a shared understanding of the evaluation objectives and approach among attendees, build rapport and identify potential participants for Phase 2, and obtain their support in the recruitment of participants amongst their staff.

Informal field notes were recorded ad-hoc and collated from these focus groups, but since the discussions were largely to aid to the researchers' understanding of the project context rather than a product of the research itself, a detailed analysis was not undertaken of the data for this phase.

Phase 2

Phase 2 involved establishing PAR groups for the three workstreams. PAR group participants were identified through contacts made in Phase 1, involving four or five practitioners from ABSS delivery partners from each workstream. Four sets of workshops were held with each group between 2022 and 2023. This phase of the project involved speech and language therapists and assistants (n= 4), health visitors and assistants (n=3), support workers (n=2) and nurses (n=1). Though, following the initial meetings there was a degree of dropout over time (see Table 1 for Phase 2 workshop participant details).

Phase 2 PAR workshops aimed to identify key barriers in delivering ABSS services, reaching disadvantaged groups and gaps in equity of access to ABSS services. To achieve this, we used varied methods including focus groups, enriched with spidergrams, service mapping and photovoice. Due to the nature of PAR research, whilst each method was introduced to each workstream, the participants were empowered to have autonomy over how they were utilised and the outputs they produced. These methods will each be described in turn, below. The four workshops were all audio recorded and transcribed, and were organised as follows:

1. An initial workshop, focused on rapport building and developing a shared understanding of services and programmes, using spidergrams and/ or service maps, followed by a focus group on the challenges and barriers in offering continuity

of care. The workshop also involved objective setting for photovoice and training on how to undertake photovoice.

2. Two photovoice workshops spaced across 2 months where the Evaluation Team facilitated discussion on the images brought by participants; prompting discussion on differences and similarities across participants' experiences.

3. Final third photovoice meeting to develop collective analysis and the photovoice exhibit.

Table 1. Participants for Phase 2 across each workshop and strand.

Workstream	Service delivery staff present in each Workshop (*n*)			
	Workshop 1	Workshop 2	Workshop 3	Workshop 4
Communication and Language	3	4	4	4
Social and emotional	3	3	3	2
Diet and nutrition	3	3	3	1

Spidergrams

Spidergrams are visual tools often used to collectively brainstorm and record discussions, whereby important components, issues or questions can be identified, and answers or solutions deliberated upon. They are used flexibly in qualitative research, and considered especially useful for when issues can be broken down into smaller parts (Lynam, 2001). We tasked participants with discussing and recording, using spidergrams, what the ***main barriers were to deliver their roles and meeting the objectives*** of the ABSS programme, if they felt comfortable to do so. They were asked to consider the programmes they deliver and identify the barriers, and the subsequent discussion of each was captured as branches on the spidergram, which comprised more detail on the issue, different facets of the issue and possible solutions. These provided space for reflection for the service mapping activity (described below).

Service mapping

Participatory mapping is used in varied and creative forms across fields, but broadly describes an interactive visual method to tackle specific questions, which facilitate a process of description, to elaboration, to theorisation which can complement traditional verbal

approaches (Emmel, 2008). For the purpose of this study, a modified technique was used whereby participants were tasked with visualising their associated service pathway and to reflect on what they consider their *ideal service pathway* for achieving the objective of their respective workstream would be, if resources were not a constraint. This visual activity aimed to understand what practitioners wanted to see from their service and why and empower them to hypothetically design the care pathways that would achieve success and good healthy child development. The pathways also stimulated reflection on the policy, system and other challenges and barriers that did not allow services to be delivered in this ideal manner.

Photovoice

Photovoice is an established research method used to help gather information about people's views of their own lives (Wang, 1999).In particular, photovoice is commonly used to explore health and inequalities in a community setting (see e.g. Haque and Eng, 2011; Kapilashrami and Marsden, 2018) and considered a useful approach to improving health knowledge (Halvorsrud *et al.*, 2022). Photovoice invites community members to share photographs and discuss them as a means of recording and reflecting on 'strengths and concerns' of their community and promote critical dialogue about them (Wang, 1999).

In our project, participants were asked to take *photographs of 'resources' (objects, services, spaces or places) that can be perceived as enabling* for the health of children and families living in the ABSS wards vis-à-vis the programme objectives (healthy nutrition and diet; improved language and communication for early years; social and emotional development). They were tasked with taking photographs to illustrate these resources, their distribution, and what facilitates or hinders access to them. Participants brought these photographs to workshops 2 and 3, to discuss as a group, what the photos say about health in relation to ABSS objectives and outcomes. To structure the discussion, we drew on the SHOWeD framework, described by Wang (1999), and amended for previous research (Kapilashrami & Marsden), which serves as a prompt for facilitators for a guided discussion about the photographs that participants provide. This is outlined below:

S – What do we **S**ee here? Describe what's in the picture

H – What is really **H**appening here?

O – How does this relate to **O**ur lives? And does it relate to/ affect all lives equally?

We – **W**hy does this situation, resource, or concern **E**xist?

D – What can we/others **D**o about it?

AND - how does participation in this exercise, with the researcher present, affect what you capture, describe and share?

In the final workshop, common themes were identified, and participants collectively selected the most pertinent images and co-produced a description and analysis which reflected the core problem and key messages for policy decision-makers.

Analysis

Analysis was undertaken of each component (spidergrams, service maps, photovoice) individually as well as collectively, with the aim to offer a comprehensive synthesis of these findings, triangulating the data collected through each method.

Issues described in the spidergram activity were *summarised* by the researchers and consolidated into short descriptions.

Data generated through service maps was inspected and analysed through comparing components of maps to identify a *typology* for an ideal early childhood public health service.

The photovoice was analysed by participants and researchers and drew on the analytic framework outlined by Tsang (2020) which indicates a process of researcher analysis, participant analysis followed by cross-checking and finally theorisation. In deviation to Tsang's framework, analysis was largely in partnership between researcher and participant. This dialogic approach aimed to empower participants further and position them equally in the research process. Analysis was achieved through participant-led production of a photovoice exhibit for dissemination displays and further theoretical analysis by the researchers which drew on these outputs as well as full transcripts of discussions obtained from the workshops across workstreams. The theoretical analysis is provided in this report.

For this, transcripts were disassembled and coded, then reassembled into themes (drawing on thematic analysis approach as outlined by Braun and Clarke (2021)), which comprised a set of codes. Some codes were inductively influenced by themes and sub-themes identified by participants in the photovoice but not exclusively.

Triangulation and synthesis

Triangulation was also supported through the rich qualitative data obtained through transcripts of all discussions held in Phase 1 and 2. Outputs from across methods were compared and cross-referenced. Broader themes emerging from this exercise were synthesised. This process is summarised in Figure 1.

Figure 1. Data analysis process.

Raw data	Processed data	Triangulated data
Spidergrams	Typology	Cross-referenced across and within each workstream, and collectively synthesised.
Service maps		
Photos	Photovoice exhibit and theorisation	
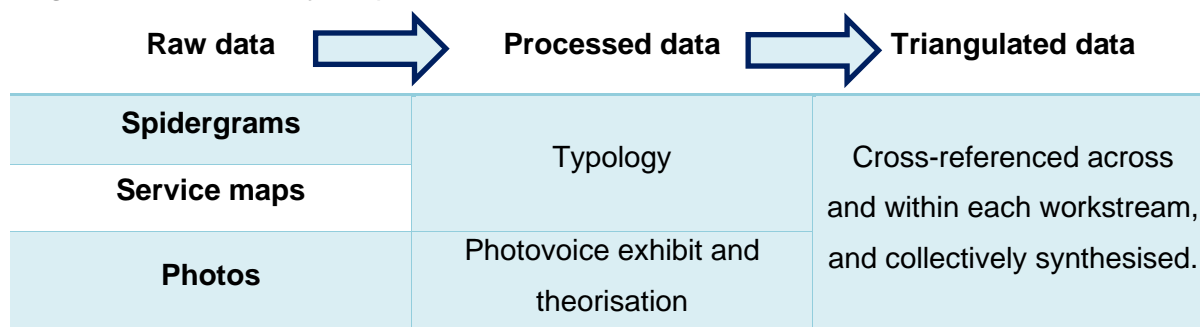
Findings

Service mapping

The service maps developed by the PAR participants are overleaf (Figures 2a-2c). These vary in design and format, as each group chose to approach this task variously and in different degrees of detail. For example, the diet and nutrition workstream illustrated the current service and how to build on it, with detailed focus on identifying barriers - but this was approached differently by other workstreams. The communication and language workstream focused primarily on sharing what was in their current remit, and so this method was used for information sharing rather than devising a pathway at that stage. The social and emotional workstream mapped their existing pathway to then articulate improvements that were needed (for example, more ante-natal classes) that pointed to current deficits. Figure 2a and 2b also exemplify how the spidergrams recording initial reflections about barriers were extended to form the basis of the 'ideal pathway' in the Diet and Nutrition workstream. Collectively, the maps and the desired pathways and their elements can be described through a typological spectrum summarised as: *'when', 'who' and 'how''*.

Typology

When mapping their ideal service, or discussing deficits in current ones, participants emphasised the importance of continuity of care across all life stages of the intended beneficiaries. In the schematics, they often identified the sequence in which health and care services are provided, aligning these chronologically to the age of the child and the stage of pregnancy/birth, associated with 'when'.

Reflecting on 'who' prompted them to discuss inequities in the region, identify different approaches in designing services and parallel pathways that would reach different kinds of beneficiaries depending on their need.

In addition to when and who, participants often referred to what they perceive the delivery of ideal care to look like and incorporated this in their mapping. This was framed as 'how'.

These are explored in more detail in Figure 3.

Figure 2a. Diet and nutrition – example of spidergrams informing ideal pathway. 'Barriers' are highlighted on sticky notes.
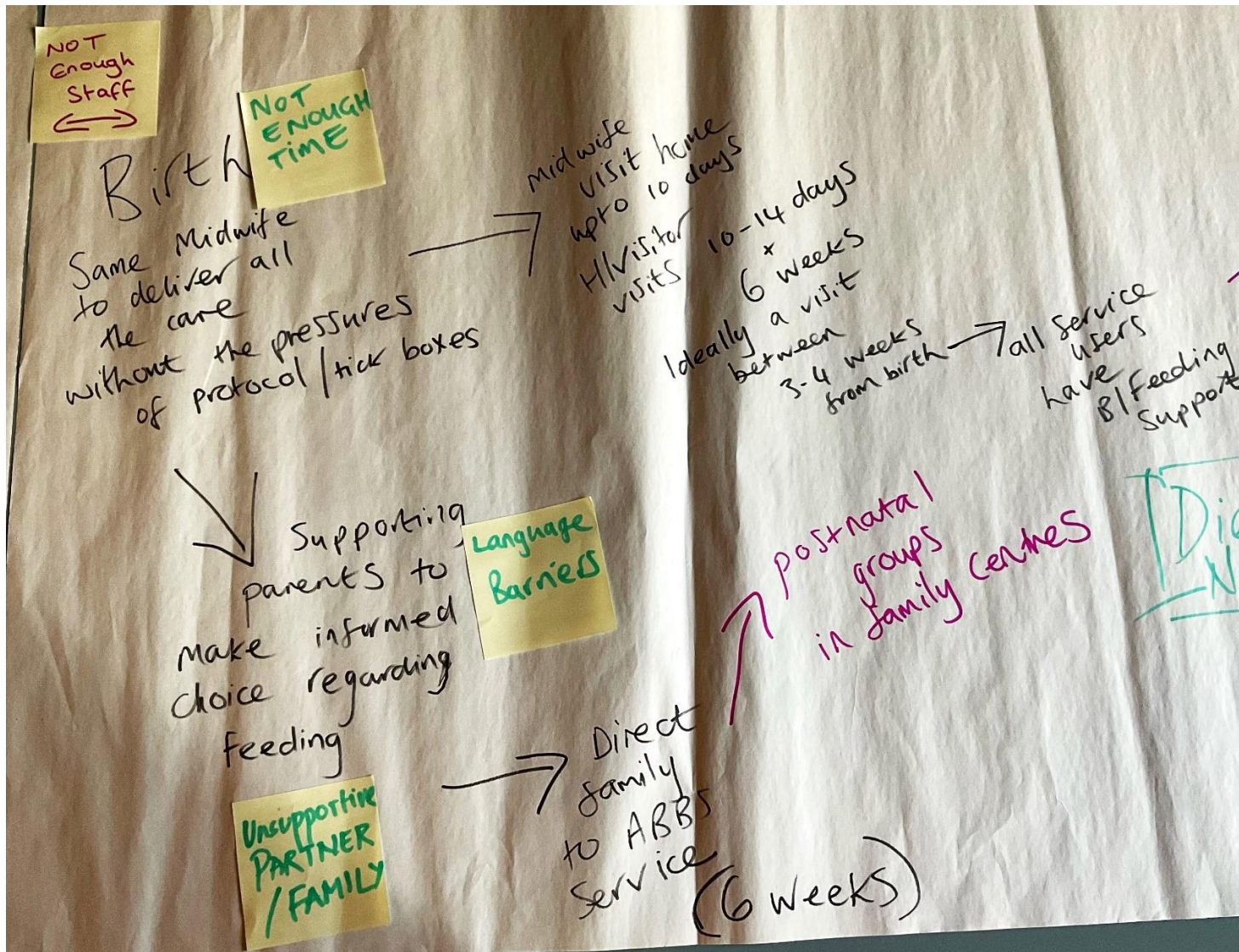
Figure 2b. Diet and nutrition strand - pathway mapping

Current pathway	Where?	Ideal pathway - additions	Challenges
Education regarding health/ nutrition/breastfeeding	Schools		
Pre-conception advice Antenatal referral and visits (biomedical) Antenatal education sessions (parental education on birth, breastfeeding, health, diet, general baby care)	Leaflets, GP Antenatal clinics, family centres 28 weeks = health visitor appointment and infant feeding adviser	Family planning Regular visits, continuity of community midwives More communication with health visitors and midwives Resuming of antenatal groups/education sessions (which stopped during Covid)	
Birth (Supporting parents to make informed decision regarding feeding)	Hospital (unless home birth)	Same midwife throughout pregnancy and birth to deliver all the care, without the pressures of protocols/tick boxes Infant feeding support for all parents, prior to 10 days	Unsupportive partner/ family for breastfeeding
Post natal Family directed to ABSS services at 6 weeks	Midwife home visit up to 10-14 days Two health visitor home visits at 10-14 days and 6 weeks	Additional health visitor visit around 3-4 weeks after birth All parents have breastfeeding support	
Bump to Breast groups Post natal groups		Being able to call an antenatal group back as a post natal group Joining up family centres and HVs/HVAs for antenatal and post natal support	
3-4 month contact with health visitors (introduction to solids) 1 year check by health visitor (diet, health, safety etc) 2 year check by health visitor (diet, health, safety etc) 5th birthday check by health visitor (diet, health, safety etc)		7 month check (in addition to 1 year check) Additional 18 month check by health visitor Additional 3 1/2 year check by health visitor	Many families don't want this for their second + child(ren) Poor previous experience of services Family interference

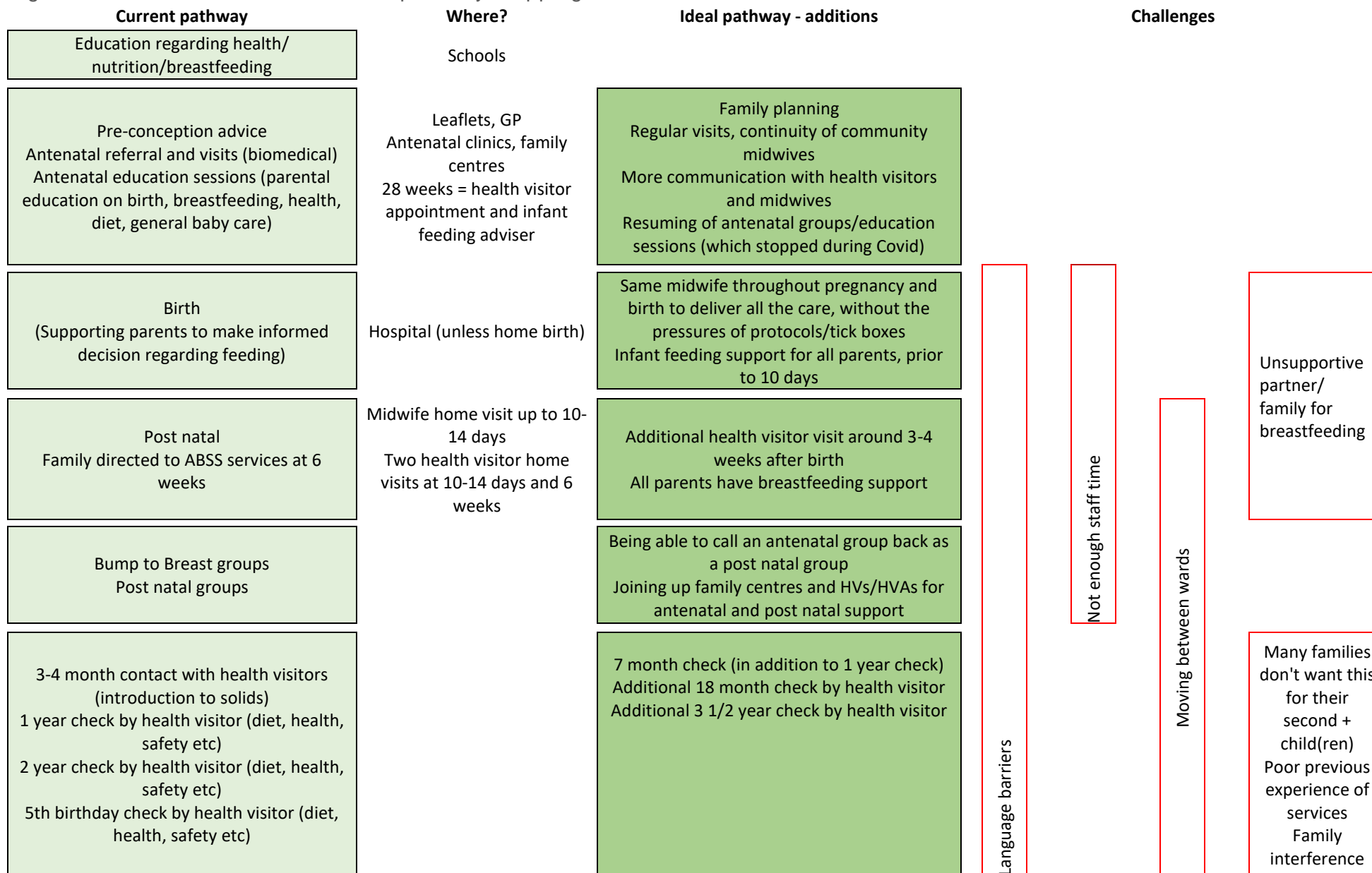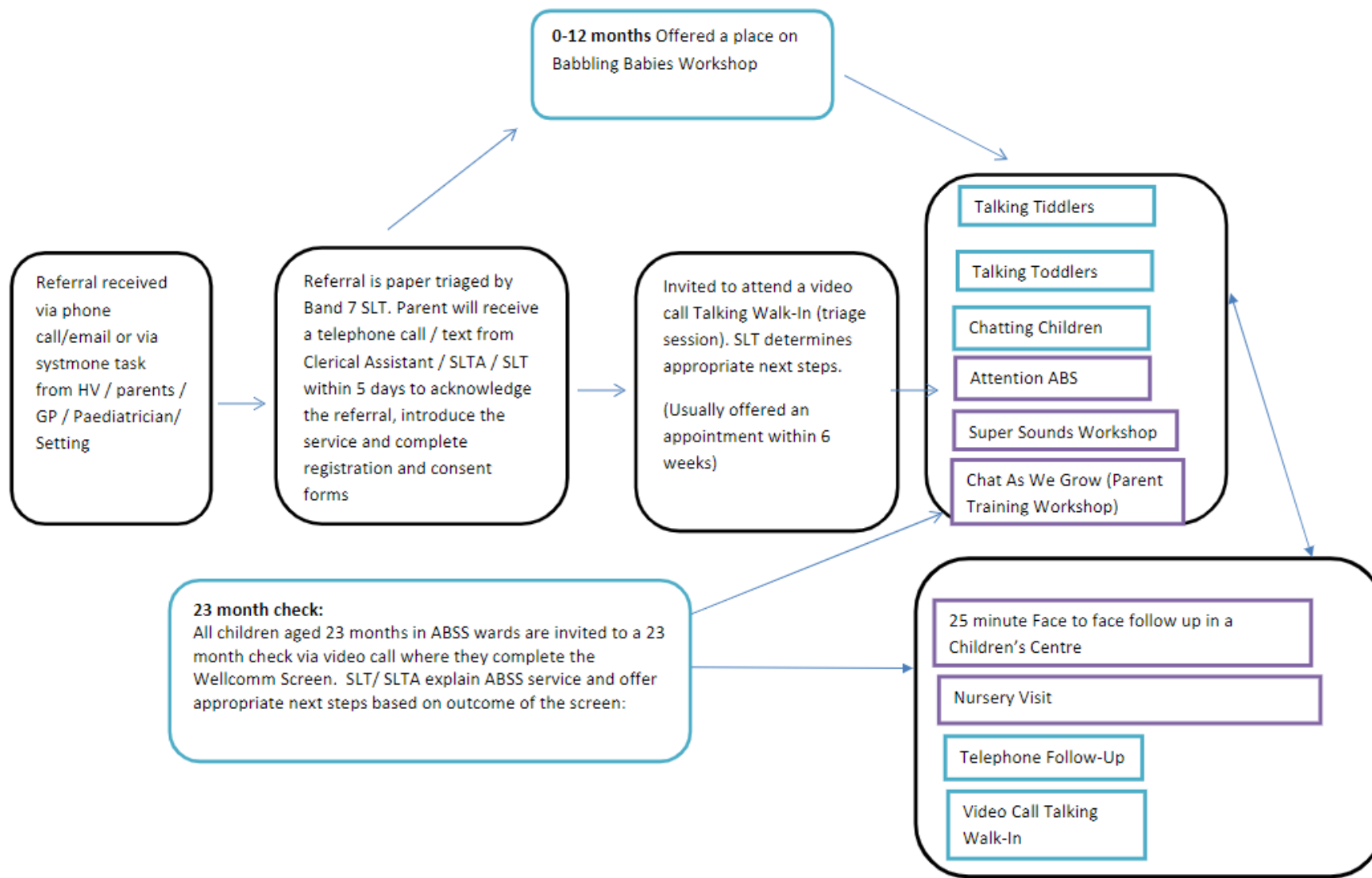Challenges (vertical labels): Language barriers · Not enough staff time · Moving between wards

Figure 2c. Language and communication –pathway mapping

Blue squares indicate 'universal' services offered to all children who come into the services.

Purple squares indicate 'targeted' services, where specific concerns have been raised with the child's speech, language, or communication.

0-12 months Offered a place on Babbling Babies Workshop

Referral received via phone call/email or via systmone task from HV / parents / GP / Paediatrician/ Setting

Referral is paper triaged by Band 7 SLT. Parent will receive a telephone call / text from Clerical Assistant / SLTA / SLT within 5 days to acknowledge the referral, introduce the service and complete registration and consent forms

Invited to attend a video call Talking Walk-In (triage session). SLT determines appropriate next steps.

(Usually offered an appointment within 6 weeks)

Talking Tiddlers
Talking Toddlers
Chatting Children
Attention ABS
Super Sounds Workshop
Chat As We Grow (Parent Training Workshop)

23 month check:
All children aged 23 months in ABSS wards are invited to a 23 month check via video call where they complete the Wellcomm Screen. SLT/ SLTA explain ABSS service and offer appropriate next steps based on outcome of the screen:

25 minute Face to face follow up in a Children's Centre
Nursery Visit
Telephone Follow-Up
Video Call Talking Walk-In

Note: In addition, there is an 'enhanced' offer which includes additional services where engagement in the usual pathway is challenging for families.

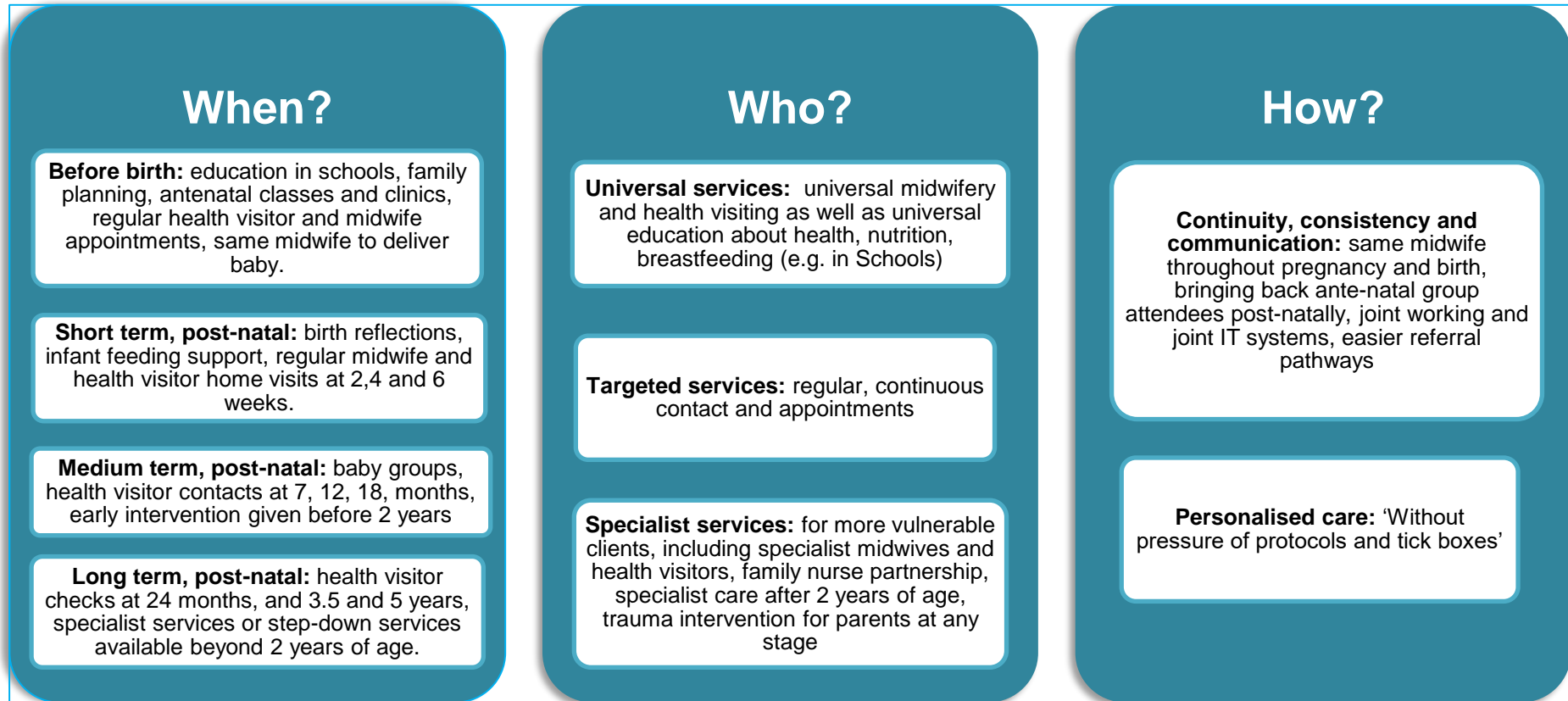Figure 2d. Social and emotional– pathway mapping

Universal services	Ideal pathway would include:	Services for more vulnerable clients
Midwifery	More antenatal classes, and to provide guidance on: - managing parents' emotional needs - responsive parenting	Specialist midwives
	Birth reflection for all parents	
	Joint working and IT joint systems - for midwives, GPs and anyone in health working with a family	
Universal health visiting	Early intervention for social and emotional difficulties (earlier than 2 years)	Specialist health visitors
	More direct referral pathways for onward services (e.g. SLT or paediatrician)	
	Continuation of specialist services beyond 2 years of age - especially FNP and specialist HVs - or a step down service	Family Nurse Partnership
	Intervention for parents to work on childhood trauma at any stage	

Figure 3. Typological spectrum to describe ideal services in the early years, with examples from each ABSS workstream.

When?

Before birth: education in schools, family planning, antenatal classes and clinics, regular health visitor and midwife appointments, same midwife to deliver baby.

Short term, post-natal: birth reflections, infant feeding support, regular midwife and health visitor home visits at 2,4 and 6 weeks.

Medium term, post-natal: baby groups, health visitor contacts at 7, 12, 18, months, early intervention given before 2 years

Long term, post-natal: health visitor checks at 24 months, and 3.5 and 5 years, specialist services or step-down services available beyond 2 years of age.

Who?

Universal services: universal midwifery and health visiting as well as universal education about health, nutrition, breastfeeding (e.g. in Schools)

Targeted services: regular, continuous contact and appointments

Specialist services: for more vulnerable clients, including specialist midwives and health visitors, family nurse partnership, specialist care after 2 years of age, trauma intervention for parents at any stage

How?

Continuity, consistency and communication: same midwife throughout pregnancy and birth, bringing back ante-natal group attendees post-natally, joint working and joint IT systems, easier referral pathways

Personalised care: 'Without pressure of protocols and tick boxes'

Photovoice

Participants across workstreams in the first PAR meetings while sharing current state of provisioning, and idealised pathways, identified key gaps in service provision. These have been summarised by the researchers as:

- Insufficient antenatal classes
- Lack of continuation of specialist services or a step-down service when children reach the maximum age of a specialist service, to offer some continuity across different life stages
- Limited support for childhood trauma
- Inadequate support for neurodivergent parents (e.g. autism/AHDH diagnoses plus subsequent support) to be able to engage effectively in ABSS services
- Delayed referrals to services for children with obvious developmental delays/SEND

Participants also noted the suspension of some successful/effective services (e.g., young mums' group) post-Covid. Whilst this may be a product of the timing of the data collection, it should be highlighted that participants identified that the gaps had remained due to lack of resources.

Gaps in provision were then elaborated upon by participants, who were prompted to discuss the challenges with ABSS delivery more broadly. The schematic in Figure 4 (overleaf) provides a succinct visual overview, produced by the researchers which summarises these challenges, across workstreams.

Subsequently, the photovoice analysis were prepared for each ABSS workstream, which varied with regards to the number of themes and sub themes generated and photos the participants felt most important to include. This co-produced work culminates in a photovoice exhibit, forming another output from the PAR work.

Theorisation

The qualitative data obtained from the photovoice meetings from all three workstreams were coded based on pertinent points made in the discussion that related to the research questions. Using NVivo software, codes were assigned to excerpts from the transcripts. These codes were reviewed alongside all workstreams' photovoice outputs and explored further. More detail is provided overleaf, following Figure 4.
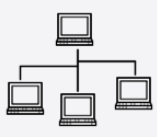
Challenges for services		Wider system challenges
Very diverse population in terms of ethnicity, migration (refugee) status that are hard to reach	Awareness of/access to services	Housing is the biggest challenge to social and emotional wellbeing
Postcode selection and resulting disparities in service uptake in the same neighbourhood	Engaging parents and 'no shows'	Poor public transport in Southend
Shortage of staff (midwives and health visitors) affecting continuity of provision	Accuracy of referrals to clinical services	Cost of living impacting on nutrition security for children (and adults)
No single IT system accessible by ALL professionals working with families	Funding for services comes to an end in two years' time – what happens then?	Lower pay for workforce generally in Southend (no London weighting)

Figure 4. Thematic visual depiction of challenges for ABSS services, discussed across workstreams in the initial PAR meeting.

Major themes from across workstreams were identified from codes which related to collective, wider issues. These are: (1) Commercial and social determinants; (2) Social-cultural attitudes and stigma; (3) System issues and (4) Education and intervention. These themes are described in detail, with illustrative quotes and excerpts from the photovoice, below.

1) Commercial and social determinants

Participants of the diet and nutrition theme emphasised the role of the sizeable baby food industry that is deploying aggressive, and often harmful, marketing strategies. The evidence provided by participants indicated that the industry makes their products seem healthy and age-appropriate, though this is often not the case and counter to public health advice. These shape breastfeeding practices and influence diet and nutritional uptake in early years. Participants documented the range of products, misinformation around them and the marketing that exploits parents' pursuits of giving their baby 'the best', whilst offering products that are unlikely to be the optimal options for baby health and nutrition.

> *"They're attracted to the colour. The colours are lovely. The colours are wonderful, bright red, beautiful pink colours, strawberry yoghurt. It's the attractive, the colour".*
>
> *"Because there's always this pressure of whether you're parenting right. And whether you prove this, by providing sufficiently for the child. And then there is almost this pressure and obligation of buying."*

There was strong reference to the cost-of-living crises and austerity amid which, these practices of commercial companies appear to be exacerbating issues around affordability and food poverty.

Illustrative excerpt from the diet and nutrition workstream's photovoice on the theme **"Food poverty - High commodity items".**

"...Formula is seen as quite a high commodity. So, you will find people selling it on...They're stealing it, so that's why there's security tags on it"

Often, marketing strategies are successful, and parents will purchase these products even when they do not really have the financial means to do so.

> *"They [parents living in deprivation] will sacrifice something else to buy that [baby food] … you still see a lot of the people with poverty buying them."*

This poses a huge barrier to facilitating good health and wellbeing in the early years and poses direct competition with public health messaging provided through services like ABSS.

Across all three workstreams, complex social factors were discussed as barriers to both sustaining healthy lives and good child development in general as well as access to services when children or families were at risk of not sustaining this. Challenging personal circumstances and chaotic lives that those most disadvantaged experience was identified as a major barrier in uptake of services.

Illustrative excerpt from the communication and language workstream's photovoice on the theme **"Parental/carer engagement vs. missed opportunities"**

"Sometimes parents, they may have other things going on in the background, whether it be housing, their own mental health or domestic issues, which are taking more of a priority than their maybe child speech and language, understandably depending on what the issue is. That would be a big preventative for a family accessing our services"

For example, insecure and inhabitable housing were a major barrier reported by participants in all workstreams. Participants reflected on how physically (in)conducive environments in social housing or temporary accommodations were detrimental for development and wellbeing in terms of rooms and space to eat and play.

Furthermore, the unaffordable (and sometimes illegal) rental market were significant perpetuating factors associated with poverty, and to stunting good child development.

"I've had a lot of children when they're in studio flats, their gross motor [skills], they're nearly always delayed when they're not able to…actually play, are they? They're not able to do the normal things like ride a bike outside or in garden."

"They went to the council; the council said you need to find somewhere to private rent. When they tried to do that, they were in a small box room. There was room for a mattress on the floor. This is when she was pregnant, with her partner…. And he was charging something like five hundred pounds."

These small and often expensive living spaces were directly linked to wellbeing and development of children across all three workstreams. For example, the diet and nutrition professionals discussed how small living spaces such as this meant fridges could not be kept, and so food sources were limited to ambient preservatives – meaning fresh food was not common. The communication and language group reflected on how having a lack of space meant key communication routines such as during mealtimes were a challenge. The social and emotional group also identified similar issues, but noted how physical space related challenges are exacerbated in case of children (or parents) with special educational needs, such as sensory challenges.

In addition to the size of the physical spaces, temporary housing was often damp and inhospitable, and inconducive for parents and families to get in and out of the house, to participate in their community and attend services hosted in clinics.

Illustrative excerpt from the social and emotional workstream's photovoice on the theme **"Accessibility of community assets".**

"One of the mums I've seen has got two children, obviously one in a pram... what do you do? How do you get your children down those stairs even to get out to get food or milk? One wrong move, and it's like the whole buggy could go down or the child could go down"

> *"The other big tower blocks, quite a lot of the time there's one lift out…It's not nice to be in… But there's no other choice than to bump your buggy down those stairs, and hold your child, it's impossible."*

This was further perpetuated for transient populations such as refugees or others in temporary or emergency accommodation who were constantly 'moved around' as services could not be provided swiftly enough before they relocated.

The cultural, linguistic, and ethnic diversity of the Southend population was widely acknowledged by participants. On the one hand, challenges were noted including overcoming differing views on health and disability across cultures, but this was accompanied by a lack of culturally sensitive and/or multilingual resources in services.

Illustrative excerpt from the social and emotional workstream's photovoice on the theme **"Social Stigma – building relationships and tackling cultural barriers to mental health".**

"We integrated with [a] religious celebration to try and offer our services. But ...in terms of money and funding...we can't do any of that work until we've got the capacity...Research shows that actually we need to get in there. We need to get into those places where people feel comfortable to talk, to be able to offer that support...it takes a long time of going to these issues and being there for people then to eventually come and see you"

On the other hand, participants also emphasised cultural and religious practices, such as prayer and strong community support and cohesion, offered benefits for wellbeing and health reducing the perceived need for services. These complex and intertwined issues signal that until some of the more basic needs of the community are met both within and outside health services (e.g. good quality housing but also culturally and linguistically accessible services), initiatives such as ABSS may not achieve its goals.

Such issues - the inability to have basic needs such as shelter, and nutrition fulfilled as well as potentially discriminating or inaccessible services - posed threats to healthy living and good child development.

2) Socio-cultural attitudes and stigma

Evident from participant discussions was that societal attitudes and beliefs related to illness and disability, but also around parenting and child-rearing practices, perpetuated barriers to access support for mental health, wellbeing, and child development. Persisting societal stigma around families and behaviours (including young or teenage parents, parents and/or children with special educational needs or mental health difficulties, LGBTQIA+ families) evoked a resistance to access services or simply going into the community, due to fear of judgement from others.

"Some of them [teenage mothers], they are really anxious, but some of them can really look at their child and know that my child needs this, and they'll overcome that with support. So, if you go with them the first time or get someone to go with them the first time, if they really love it, the chance[s] are they'll go back. But then we do have some girls that it doesn't matter how much you offer to go with them, they're not going"

"[When] going out into the community and being able to actually access any services, this is pretty much how they feel, basically judgment. So, when they go out to a session or speak to a paediatrician or whatever, the first word that we always hear is, 'I'm afraid to be judged because of how my child behaves or because of what's wrong with my child.'"

Illustrative excerpt from the social and emotional workstream's photovoice on the theme **"Societal stigma – breaking barriers and inclusive practices".**

"I think there needs to be more groups for specific groups. A lot of girls don't want to go to groups where there's older parents because they feel judged by them."

"You kind of feel like you have to go to SEND only sessions rather than normal playgroups or normal sessions that are being run at family centre...The judgment just is real. And it's not just from people, it's also from staff as well that are not trained to deal with certain situations"

These concerns speak to the need to address much higher social and policy influences such as the inclusion agenda, and the ways in which health and disability are framed in both the mainstream and the marginalised. Based on this, taking a more comprehensive and holistic approach to developing public health initiatives appears crucial.

3) System issues

Systems for supporting health, wellbeing and holistic child development are complex, comprising simultaneously of many different positive components, whilst also suffering from sustained gaps. The excerpts illustrate some of these examples of significant gaps in the system.

"...we cover zero to four [years], but our parents would actually like us to go beyond four. Because as you can imagine, they normally get that diagnosis around the three to four ages, and by the time we finish with them and they've completed the journey. But then you start the journey of EHCPs and school and then the anxieties around that…So we get a lot of requests to continue services past four because special needs children don't stop being special needs children at four, they continue for life."

"I actually feel like actual parenting classes should be done when you're pregnant. And I'm pretty sure they do them in other countries, they just don't do it here. And I do think it's that whole thing of if you didn't get that as a child, how do you know how to do it?

Whilst specific parts of the ABSS programme hold the potential for benefit, their impact may be limited by many other parts of the health and care system, which are beyond the control of ABSS services.

Where services within ABSS were more integrated, this was seen as beneficial. However, surface-level attempts of integration of services were also highlighted.

"So, this part of trying to align our services, so that we are doing the same and saying the same…, it just makes it easier for the parents, doesn't it really? Because that's what you want after you've had a baby.

…No that's a really important point. Like how do you align these services? How do you make sure that the experience is seamless? I mean the whole pathway experience and I think that aligning, joining all our services become key to that".

"We're working in silos and we're not working together. So seemingly if you look at it, it looks like we're working together because we're attending meetings, but actually we are not. We are defective."

Staff highlighted the uncertain and changeable situations and lives of their target service users that makes it harder to establish rapport and trust; and constant changes and understaffing can have a massive detrimental impact here.

Illustrative excerpt from the communication and language workstream's photovoice on the theme **"Parents/carers and professionals are stretched".**

"Parents have to prioritize what's most important to them, don't they? And is it their child's communication or language at the end of the day? Or rather greater needs, or other priorities... and maybe parents may feel stretched [to] capacity, possibly juggling their own health… with those of their child... they're being pulled because they've got so many different appointments to attend... or they could be caring for other family members."

When parents' and families' energy is focused on fulfilling basic needs of finding housing and affording food, any additional layer of complexity in sustainably engaging in health initiatives (for example: having a change in staff member contact due to staff leaving, needing to repeat a medical history to multiple professionals due to lack of patient data sharing, and the demand to keep abreast of the involvement of multiple agencies, care pathways and services) bears considerable weight in the potential for benefit. Thus, initiatives like ABSS are unlikely to succeed, unless there is a much wider, multi-level and larger scale effort to collectively address basic needs, service needs and system's needs.

4) Education and intervention

As characteristic of public health interventions, much of the work done as part of the ABSS programme has revolved around education and subsequently early intervention. This was considered a positive and advantage of ABSS over usual care.

> *"I think this whole project really is important that it's the education. If they haven't got the support and the education, they give up."*

The importance of evidence-based public health education was spoken about particularly in relation to infant nutrition and 'early days' of child rearing where perhaps parents are more anxious and vulnerable to listening to those closest to them. Social media was also referred to as a source of influence and often 'misinformation', which also resonates with some of the marketing tactics of baby food products, as discussed earlier. Participants felt that education was therefore an important part of their role. This theme signalled that ABSS, for all the challenges it faced, providing education can always go a long way and thus remains an effective and integral component of the public health approach.

Illustrative excerpt from the diet and nutrition workstream's photovoice on the theme **"Investing in scaling local innovation- normalising breastfeeding"**.

"They represent health, they represent colostrum, how to massage, how to position, how to attach, and when you walk onto a ward with them in the morning with a fake baby and one of them, it actually lightens up the mood in the room with the dad there and the mum there. And you can really, it makes them feel relaxed then."

Synthesis of PAR findings

Each of the creative methods used in this part of the evaluation have produced unique and insightful assessments of the ABSS programme, and each addresses the questions we set out to answer in this evaluation, pertaining to the barriers to delivering quality care and meeting the programmes objectives. However, the methodological approach adopted here allows for a more critical synthesis of these findings. The researchers have explored in detail the collective findings from the pathway mapping exercises, focus group discussions related to the gaps and challenges of ABSS, and the photovoice discussions. Subsequently, a critical examination the three most significant findings is presented, being: (1) Value added from ABSS; (2) Wider challenges beyond the remit of ABSS; (3) Shortcomings in ABSS service provision and management; and (4) Political agendas and priorities.

Value added from ABSS

A recurring theme and finding across the PAR was the perceived value add of the ABSS services and projects to the community. ABSS staff expressed a strong belief that ABSS programmes benefit children and families these engage by promoting their health and well-being, citing 'success stories' and examples of where participants' intervention had made a difference to the lives of individuals, and the education to families provided through ABSS was a much valued component and opportunity for influencing good child health.

Wider challenges beyond the remit of ABSS

However, despite these 'success stories', there were clear identification of gaps, and reflections on how they could be overcome to meet the programme objectives.

Critical reflections from participants signalled challenges in effectively supporting those who may be considered most in need of additional support, and thereby not fully meeting the aims of ABSS. They identified these populations as those living in greater socio-economic deprivation, who are linguistically or culturally diverse, are homeless or living in temporary and poor housing, who have mental health difficulties or who for other reasons lack social and economic capital (for example, 'young mum' care leavers). Wider social determinants of early years development such as poor housing and public transport were commonly reported factors as were commercial influences (e.g. marketing of baby foods) in the diet and nutrition group but also pertinent across groups were issues regarding the private and social rental market. The need for joined up working and action across sectors thus was predominant and may be related to the fact that the PAR activity brought together different professionals for the first time to collectively reflect on the challenges. Socio-political influences such as the impact of austerity and the cost-of-living crisis were also widely referred to by all participants. Overcoming challenges and barriers to effectively supporting communities fully in this way therefore sometimes appeared beyond the remit of the staff and the ABSS programme, and such initiatives may not be sufficient when there are wider determinants at play.

Some services provided through ABSS attempted to compensate for some of these wider challenges, such as providing education about breastfeeding and infant nutrition information to counter the misinformation provided by the industry, the offer of home visits rather than requiring families to travel to clinic appointments, and staff providing evidence to councils to support housing claimants. Whilst these efforts and components of the programmes would hopefully positively impact the individuals who engage, addressing the system-wide issues do not appear integral enough to the programme to alleviate the barriers for the many.

Shortcomings in the ABSS service provision and management

The context of health services existing in a diverse, multi-cultural and multi-lingual community demands services designed to meet these needs. In many cases, this evaluation indicated this was not always applied in the ABSS programmes. There was a distinct lack of resources for interpreter services, translation of materials and evidence-based information relevant to the majority (such as language development norms of languages other than for monolingual, English speaking children). In addition to this, shortcomings were evident in relation to general staff capacity, where both absence and inconsistency of professionals were considered to hamper more positive outcomes. Staff felt over-stretched and in constant 'firefighting' mode, given the complexity of issues experienced by carers and parents.

Staffing issues were paired with the difficulty of the siloed nature of the interventions delivered through ABSS, which emerged as a significant barrier. In the service mapping

activity, for example, some components of current pathways were maintained (e.g., pre-conception advice) but when participants expanded on in the *ideal* pathway, solutions were more integrated (e.g., providing pre-conception and family planning advice). In the photovoice, participants described how beneficiaries attending one ABSS activity group then supported them to access more of their services – highlighting some success in this area.

Another aspect of the model of ABSS considered challenging was the ward-level allocation of services that created conflict in the community where neighbours, families and friends had different access, and staff, utilising their autonomy and professional commitment to deliver care would sometimes spend time consulting people who were not eligible for ABSS services. Such prioritising and management decisions appear to have posed limitations directly on the effectiveness of the programme, though it is acknowledged that this part of the design was a condition of the funder and as such, outside of the ABSS team's control. Future programmes need careful planning and communication around programme pilots and appropriate compensation/ alternatives for those not included in the pilots.

Political agendas and priorities

Ideal pathways outlined by participants can serve as a blueprint for ways forward for the planning and delivery of public services to support better health and wellbeing of children in Southend. However, the evaluation reveals significant barriers- at programme, community, and system levels- which undermine planning, funding and uptake of effective health services and care pathways. The ABSS programmes do appear to have enhanced the local offer and benefited the community through increasing availability and variety of services and resources, as well as using flexibility and a person-centred approach to maximise reach and impact. These appear very beneficial and a likely improvement on the local services that existed before ABSS. However, contrary to the aims of ABSS, throughout this evaluation, many instances illustrate that the programme cannot meaningfully, entirely, support some of those who may be considered most in need (for example, children with special educational needs and their carers, or parents with mental health challenges, those with temporary or poor housing, LGBTQIA+ families). These wider social determinants and political-economic environments need to be considered in the future design of the ABSS programme.

Discussion

The evaluation has highlighted both strengths of the ABSS programme (education/ awareness, flexibility, increase in services) and the limitations to achieving its aims (resources and staffing as well as competing commercial, social, political, and economic priorities). Through the PAR methodology and its use of multiple creative methods, the voices of programme delivery staff were foregrounded, and this has revealed a substantial

and nuanced assessment of ABSS that centres on issues around inequality and broader political, economic environment that constrain the delivery of outcomes. Crucially, the process of knowledge exchange between researchers and stakeholders through the PAR has positioned the practitioners as 'experts' who can empower change. This last point is reflected in the recommendations for public health policy decision makers – which are relevant to the ABSS programme in its current and future form, as well as newly emerging public health initiatives – and calls to action, below, which are based on our findings:

1. **Future commissioned place-based public health programmes should operate through a multi-systems intersectional framework that brings together partners across government departments, local authorities, councils and service providers to offer an integrated early development pathway.**

This should build on the partnership approach adopted by the ABSS programme, and be expanded to include those responsible for housing, transport, education, health and social care, local faith, and other community groups and community-led third sector organisations, as well as government departments such as the Department for Work and Pensions. Our evidence suggests that programmes, where the focus in on individuals and individual services working in silo, with limited capacity for partnerships, risk exclusion and marginalisation of those most in need who are suffering from competing life-essential priorities. An intersectional approach (i.e. one that considers marginalisation from multiple perspectives simultaneously) can help link individual factors with social determinants, and examine the diverse basis of inequalities in reaching the 'left-behind' (Kapilashrami and Hankivsky, 2018; Kapilashrami, Razavi and Majdzadeh, 2023).

2. **Greater advocacy by health professionals involved in ABSS programmes for i) greater support from public health departments for more accessible information, education and communication/ promotional campaigns for local home-based preparations for healthy diet; ii) tighter regulation of industries that directly contribute to poor health and development, not limited to but including the baby foods and the private rental market.**

The simultaneous rise in cost of products such as baby foods, and essentials like rent has directly fostered environments for poor health and wellbeing, and further poverty. The influence of commercial determinants were profound in this evaluation and have been echoed elsewhere (Brown *et al.*, 2019; Garcia *et al.*, 2020; Harris and Pomeranz, 2020)(). The influence of these national and global markets risks outcompeting community-led and undermine public-health and messages (for example, sustained healthy eating, space to play for gross motor skill development).

3. **Commissioners and directors of future community-level interventions to support early childhood health and wellbeing should target funding and resources toward developing relationships and partnerships with grass-roots schemes within marginalised communities to build trust and extend the reach and impact of the support and early intervention available.**

Significant barriers remain to accessing existing services for families with children or parents with special educational or mental health needs, from 'non-traditional' families such as LGBTQIA+ parents or of those with adopted children, and those linguistically and culturally marginalised. In any service provision, materials and approaches should reflect the diversity of the community, be culturally appropriate and available in any language. At present, while there are examples of attempts within ABSS programme to make promotional materials accessible, these are far few, ad-hoc and rely on voluntary support, and therefore inadequate to making services inclusive.

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